Unit #: _____

School Year: _____

THE CHILDREN'S CENTER AT U.C.P.
9 Smiths Lane, Commack, New York 11725
(631) 543-2338 FAX: (631) 543-5981

REGISTRATION FORM

(Please Print)

STUDENT NAME: _____ DATE COMPLETED: _____

ADDRESS: _____ DATE OF BIRTH: _____

_____ School District: _____

PARENT/GUARDIAN: _____

HOME PHONE #: _____

BUSINESS PHONE #: _____

CELL #: _____

If foster child, please note your:
Name: _____
Foster Care Agency: _____
Address: _____
Phone #: _____
Case Worker: _____

ETHNICITY:

African American	☐	Asian	☐
American Indian/Alaskan Native	☐	Hispanic or Latino	☐
Multiracial	☐	Native Hawaiian/Pacific Islander	☐
White	☐		

EMERGENCY CONTACTS:

In case of an ***Emergency***, I give permission for The Children's Center to obtain medical emergency services for my child.

YES ☐ NO ☐

In case of an ***Emergency,*** my child may be released to any of the following people:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

_____ _____
Signature of Parent/Guardian Date

TO BE RETURNED TO MAIN OFFICE